PR

the CHILD

Monthly Bulletin

MARYLAND HEALTH TRAILER

U. S. DEPARTMENT OF LABOR
CHILDREN'S BUREAU

SEPTEMBER 194

MARYLAND HEALTH TRAILER

Medical and nursing care is brought to mothers and children in rural areas of Maryland through the health trailer, operated by the Bureau of Child Hygiene of the Maryland State Department of Health. The health trailer is equipped as an examination room. The photograph on the cover shows the physician giving a complete physical examination to the young infant of a mother who has reported for postnatal care.

THE CHILD

MONTHLY BULLETIN

Volume 6, Number 3 September 1941

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Obstetric Care in Rural Areas

Based on a Study of 1,523 Births in Maryland

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Many studies of maternal deaths have been made. They have served a useful purpose because they have indicated that by different treatment before or after delivery many deaths might be prevented. They have not, however, afforded information on the care received by mothers who survived and consequently have given no body of fact with respect to the adequacy of community facilities for protection of the mother or child.

By investigating the care received by all mothers whose children are born and registered as either live births or stillbirths over a period of time, it is possible to ascertain the deficiencies in the maternity services of any area that is studied and to obtain a basis on which to formulate plans for furnishing the additional services that are needed. Such studies are especially urgent in rural areas because women who live in such areas bear more than half of the Nation's children (57 percent of the live births in the United States in 1938 were births to mothers who lived in rural areas) and because facilities for care in rural areas are well known to be less adequate than facilities for care in cities.

This study is an attempt to ascertain the general situation with respect to maternal care in the rural areas of Maryland by means of studying consecutive births (live births and stillbirths) to mothers in representative counties of the State. It is based on information for 1,523 women (1,011 white, 512 Negro) who lived in these four counties and who had children born in 1937 or 1938 whose births were registered.

The four counties were: (1) Allegany County, which is located in the western, mountainous part of the State and which has Cumberland as its county seat; (2) Anne Arundel County, which is located on the Chesapeake Bay tidewater section and which includes Annapolis, the capital of the State and the site of the United States Naval Academy; (3) Montgomery County, which has no city of as many as 10,000 population but which adjoins the District of Columbia and has a considerable suburban population; and (4) Wicomico County, which is an Eastern Shore county with several textile factories in its principal city (Salisbury) and which is given over to vegetable and fruit raising in its rural sections.

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The 1940 census shows that the four counties had a total population of 273,790 and that about three-fourths of the population lived in rural areas, that is, on farms and in towns and cities of less than 10,000 population. Figures from the State Department of Health show that the average annual number of live births to mothers who were residents of these four counties during the 3-year period 1936–38 was 4,652 (3,921 white, 731 Negro). They also show that almost nine-tenths (89.2 percent) of all live births to such mothers (96.2 percent of the white; 51.4 percent of the Negro) were attended by physicians; only about one-tenth (10.8 percent) were attended by nonmedical persons (3.8 percent of the white women, 48.6 percent of the Negro). The nonmedical persons were mainly midwives (table 1).

The health situation of mothers and babies in these four counties was slightly better than in all Maryland counties. The maternal mortality rate in the four counties was 38.7 deaths per 10,000 live births compared with 44.4 in all Maryland counties during the period 1936–38; the infant mortality rate was 61.6 deaths per 1,000 live births compared with 64.7 in all counties; and the stillbirth rate was 41.5 stillbirths per 1,000 live births compared with 46.1 for all counties (table 2).

The mortality rates for white mothers and babies in the four counties, as would be expected, were lower than those for the Negroes. The maternal mortality rate for white women (33.2) was less than half the rate for Negro women (68.4) during the period 1936–38; in like manner, the mortality rate for white infants (51.8) was less than half the rate (114.4) for Negro infants. The stillbirth rate was 36.5 per 1,000 live births for the white population, compared with 68.4 for the Negro (table 2).

All the four counties have organized health departments with full-time health officers. In each of the counties prenatal clinics for the low-income group are conducted, chiefly by local physicians, under the auspices of the State Department of Health. These clinics are visited at regular intervals by the obstetric consultant of the Bureau of Child Hygiene. At the time of the survey no provision was made for delivery service through the clinics except in cases where abnormal conditions existed.

TABLE 1.—*Average annual number of live births to resident mothers by race and attendant at birth in all Maryland counties and in the 4 counties that were studied; 1936–38*

Area and race	Total	Physician		Nonmedical attendant	
		Number	Percent	Number	Percent
All counties [1]	16,507	14,392	87.2	2,115	12.8
4 counties	4,652	4,148	89.2	504	10.8
Allegany	1,709	1,692	99.0	17	1.0
Anne Arundel	1,148	830	72.3	318	27.7
Montgomery	1,294	1,249	96.5	45	3.5
Wicomico	501	377	75.2	124	24.8
WHITE					
All counties [1]	13,466	12,821	95.2	645	4.8
4 counties	3,921	3,772	96.2	149	3.8
Allegany	1,686	1,669	99.0	17	1.0
Anne Arundel	757	690	91.1	67	8.9
Montgomery	1,115	1,106	99.2	9	.8
Wicomico	363	307	84.6	56	15.4
NEGRO					
All counties [1]	3,041	1,571	51.7	1,470	48.3
4 counties	731	376	51.4	355	48.6
Allegany	23	23	100.0	-----	-----
Anne Arundel	391	140	35.8	251	64.2
Montgomery	179	143	79.9	36	20.1
Wicomico	138	70	50.7	68	49.3

[1] Comprises the State of Maryland exclusive of Baltimore city.

Based on data from Annual Reports of the State Board of Health of Maryland.

Method of Conducting Study.

During the period of survey—1 year in Anne Arundel County, which supplied two-thirds of the material, and shorter periods in the other counties—every birth was investigated. As soon as the birth certificate was received in the county health office the public-health nurse of the district where the mother lived visited the

TABLE 2.—*Maternal and infant mortality and stillbirth rates by race for residents of all counties of Maryland and the 4 counties that were studied; 1936–38*

Area and race	Maternal mortality rate [1]	Infant mortality rate [2]	Stillbirth rate [2]
All counties [2]	44.4	64.7	46.1
4 counties	38.7	61.6	41.5
Allegany	35.1	60.5	48.8
Anne Arundel	46.5	78.1	45.9
Montgomery	25.8	45.3	28.3
Wicomico	66.6	69.9	40.6
WHITE			
All counties [3]	36.4	52.8	38.5
4 counties	33.2	51.8	36.5
Allegany	35.6	59.7	48.2
Anne Arundel	30.8	52.9	30.8
Montgomery	23.9	36.8	23.6
Wicomico	55.1	58.8	33.1
NEGRO			
All counties [3]	80.0	117.6	79.7
4 counties	68.4	114.4	68.4
Allegany	------	114.3	85.7
Anne Arundel	76.7	127.0	75.0
Montgomery	37.2	98.7	57.7
Wicomico	96.6	99.0	60.4

[1] Deaths per 10,000 live births.
[2] Deaths per 1,000 live births.
[3] Comprises the State of Maryland exclusive of Baltimore city.
Based on data from Annual Reports of the State Board of Health of Maryland.

home and filled out a survey form. The number of women whose histories were investigated in each county was:

County	*Total*	*White*	*Negro*
Total	1,523	1,011	512
Allegany	221	219	2
Anne Arundel	972	557	415
Montgomery	110	84	26
Wicomico	220	151	69

The nurse usually obtained the information for the survey form from the mother (90.6 percent); for 3.9 percent of the forms it was obtained from relatives, for 2.6 percent from the physician, and for 2.9 percent from other sources and sources not stated.

The form comprised some 60 items, which related mainly to previous child-bearing history, the complications of pregnancy and labor, the details of prenatal and delivery care, and the results of the pregnancy to the mother and child. Information was not supplied on every schedule form for every item. The informant was not always able to supply full information. Some nurses were able to secure more complete information than other nurses. Certain items of the form were found to be lacking in specificity. For the most basic information, however, the facts were usually obtained and carefully filled in.

The findings presented here are particularly those relating to prenatal and delivery care. They are expressed, therefore, in percentages of the totals for which answers were given, that is, they are based on the total number of women for whom the answers were known. For none of the items discussed was the unknown group sufficiently large to affect the significance of the finding.

The schedule count by race shows that one-third (512) of the 1,523 women included in the study were Negroes; this is a larger proportion than that shown for births in the four counties in the period 1936–38. The weighting, per se, however, does not affect the findings for the study because they are presented separately for the two racial groups.

Prenatal Care.

Prenatal care had been received by nine-tenths of the white and four-fifths of the Negro women included in the study. One-tenth of the white and one-fifth of the Negro women had had no care. Information as to whether prenatal care was received was obtained for every woman included in the study.

Prenatal care	*Percent of women*		*Number of women*	
	White	*Negro*	*White*	*Negro*
Prenatal care	90.1	78.1	911	400
No prenatal care	9.9	21.9	100	112

There is every reason to believe that prenatal care is more common today than in earlier years.

Nevertheless, it is obvious that there is plenty of room for further progress.

Most of the women who received prenatal care received it from physicians. White women usually obtained this care from private physicians; 78 percent received care solely from private physicians, compared with 31 percent of the Negro women. Half of the Negro women and 11 percent of the white women received care solely from clinics. Some women of each racial group (8 percent of the white, 12 percent of the Negro) received care from both private physicians and clinics; this percentage is explained partly by the fact that some physicians made a practice of referring to clinics for prenatal care the women of low income to whom they expected to give care at delivery.

Source of prenatal care	*Percent of women*		*Number of women*	
	White	*Negro*	*White*	*Negro*
Total women reporting care	100.0	100.0	911	400
Physician	97.6	92.8	889	371
Private physician	78.2	30.5	712	122
Clinic physician	11.3	50.0	103	200
Private and clinic physician	8.1	12.3	74	49
Public-health nurse (no physician)	2.4	7.2	22	29

A few women of both races who for one reason or another could not be brought in contact with physicians received prenatal care solely from public-health nurses. For these women the nurses, in addition to their regular work of giving health supervision and instruction through home visits, made blood-pressure readings and took samples of urine for analysis.

The public-health nurses made home visits to more than one-fifth of all the white and more than half of all the Negro women who received medical prenatal care. As would be expected, the nurses more often visited women who were clinic cases than women who were cases solely of private physicians. They visited 45 percent of the white and 75 percent of the Negro women who received care from clinics as compared with 16 percent of the white and 17 percent of the Negro women who received care solely from private physicians.

Adequacy of care.—Merely to supply prenatal care is only one step in the problem of the mother's care. The quality of the care is the important feature. If the prenatal care provided is to be adequate, it is of first importance not only that expectant mothers seek care from the physician early in pregnancy and remain under his supervision throughout the period, but also that the care given by the physician include certain types of examinations, tests, and treatment.

As a large proportion of the women included in the present study lived in rural areas where family incomes were low and few physicians appreciated the need of mothers for careful supervision throughout pregnancy, it was found necessary in determining adequate prenatal care for purposes of this study to select minimum criteria which would be met by a fair proportion of the women. These minimum criteria of adequate care were:

1. First visit for prenatal care not later than the sixth month of pregnancy.
2. At least three prenatal visits to physician or clinic.
3. Last visit not more than 5 weeks before delivery.
4. Prenatal physical examination, measurement of pelvis, blood-pressure determination, and urine analysis.

After prenatal care was graded by these minimum criteria, it was found that only 44 percent of the 911 white women and 28 percent of the 400 Negro women who received prenatal care had care of the quality termed adequate; and that 56 percent of the white and 72 percent of the Negro women had had care classified as inadequate even by these minimum criteria.

Month of pregnancy when prenatal care began.—Care was begun before the end of the second trimester of pregnancy by almost four-fifths of the white women studied and by almost

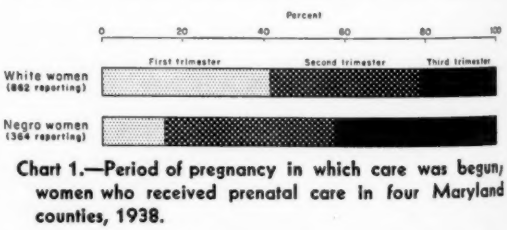

Chart 1.—Period of pregnancy in which care was begun, women who received prenatal care in four Maryland counties, 1938.

three-fifths of the Negro women. Only about one-fifth of the white women, compared with

two-fifths of the Negro women, began their prenatal care in the last trimester.

Number of visits for prenatal care.—As the number of visits for prenatal care depends in part at least upon the month of pregnancy when care begins, it is not surprising to find that a larger proportion of Negro than of white women made few visits for care. At least three visits is one of the minimum criteria for adequate care used in this study. Less than three visits were made by 56 percent of the Negro women who received care from private physicians and 52 percent of the Negro women who attended clinics. In sharp contrast, only 20 percent of the white women who received care from private physicians and only 38 percent of the white women who attended clinics made less than three visits.

Obstetricians expect an average of 10 to 12 visits in a routine, normal pregnancy. A little more than one-fifth of the white women who received care from private physicians made 10 or more visits; for each of the other groups of women the proportion was less than 10 percent.

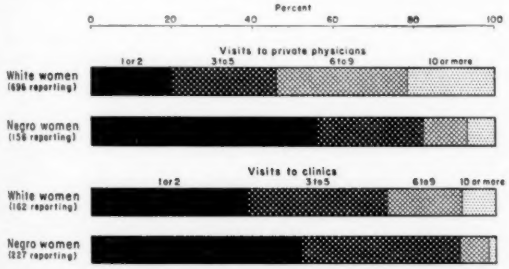

Chart 2.—Visits made to private physicians and to clinics for care, women who received prenatal care in four Maryland counties, 1938.

The marked difference between the number of visits made by white women and by Negro women is explained partly by the fact that a large number of physicians refer to clinics for prenatal care the women of low-income classes whom they expect to deliver. Also, the standard practice among many practitioners is to make an extra charge for each prenatal visit, because they have not yet come to consider such visits an essential part of obstetric care. In the low-income clinic group, work at home, difficulty in securing transportation to the few clinic centers available, and lack of appreciation of the importance of regular attendance help to explain the small number of visits.

Interval between last prenatal visit and delivery.—Almost all the women who received prenatal care had made a visit for prenatal care shortly before delivery; 92 percent of the white and 85 percent of the Negro women who received prenatal care had made a prenatal visit less than 40 days before their delivery occurred. It is a well-known fact that many women who do not seek prenatal care early in pregnancy visit a physician or a clinic in the last month in order to arrange for delivery care. The proportions just cited, of course, include women who made first visits at this time as well as women who began their care at earlier periods and made a last prenatal visit at this time.

Physical examination, pelvic measurement, blood pressure, and unrinalysis.—For almost all of the 911 white and 400 Negro women who received prenatal care information was obtained as to whether physical examination had been made, pelvis measured, blood pressure taken, and urine analyzed. The percentage of completeness of reporting was lowest for pelvic measurements, but information as to whether measurements were taken was obtained for 95 percent of the white and 94 percent of the Negro women who had received care. Findings on these aspects of care are consequently presented in terms of percentages based on total women for whom the information was obtained; that is, they are presented in the same manner as on the other criteria used in grading the adequacy of prenatal care.

Almost nine-tenths of the women of each racial group had had physical examinations, and the same proportion had had their blood pressure taken and their urine examined. A slightly larger proportion of white than of Negro women received each of these types of care, but differences in the percentages are all too small to be statistically significant.

Pelvic measurements had been made on a smaller proportion of white than of Negro women; the percentages were 65 for white and 73 for Negro women. The percentage for Negro women is significantly higher than that

for white women. This is explained by the fact that a much larger proportion of the Negro women obtain prenatal care from clinics. In the clinic group 97 percent of the women were given pelvic measurements, including internal measurements. On the other hand, only 24 percent of the women who went to private physicians for prenatal care were measured, and there is good reason to believe that in most of these cases the measurements were only external. It is a rule, of course, in the clinics that all patients be measured unless the first visit is dangerously close to term.

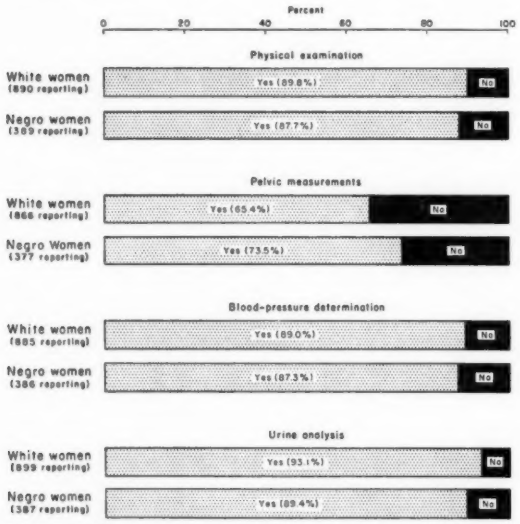

Chart 3.—Physical examination, pelvic measurements, blood-pressure determination, and urine analysis; women who received prenatal care in four Maryland counties, 1938.

The accuracy of the information with regard to physical examinations is open to some question. It will be remembered that the nurses obtained the data chiefly from mothers, who could not be expected to know what an examination should include. It is extremely difficult to make a qualitative assay of these various items. One knows that certain standards are maintained by the clinics, although the quality of the work varies to some extent from one clinic to another. Some private physicians do better work than the clinic, but, on the whole, the tendency of most rural practitioners is to see a large number of patients without giving very thorough care.

Serologic test for syphilis.—Although it is generally recognized that a serologic test for syphilis is a necessary part of prenatal care, it was not made a prerequisite of adequate care in this study, because many rural practitioners fail to accept a test for syphilis as essential. Information as to whether the test was made was obtained for practically all women who received prenatal care.

Slightly more than two-fifths of the white women (44 percent) had had serologic tests, compared with three-fourths (75 percent) of the Negro. The reason for the higher percentage of serologic tests among the Negro women appears for the most part to be the same as that for the higher percentage of pelvic measurements and is illustrated by the comparison of serologic tests made by physicians and by clinics.

Almost all the women who received care from clinics had tests (91 percent of the white, 99 percent of the Negro), compared with about a third of the white and about two-fifths of the Negro women who received care from private physicians. The taking of a serologic test is standardized procedure in clinics. The fact that the clinics did not achieve 100 percent in this item is disappointing and probably explained by oversight. This should and will be corrected.

In the clinics we attempt not only to make serologic tests on all prenatal patients but to give treatment for syphilis in all instances where the result of the test is positive. At the time of this study about 2.4 percent of the tests on white women and 25.0 percent of the tests on Negro women gave positive results. However, because of lack of cooperation on the part of some patients and difficulty in obtaining transportation to treatment centers only about three-fourths of the women whose tests were positive received any treatment and only about half of the women who started treatment received as many as eight treatments. The number of treatments the clinics were able to give to syphilitic women during pregnancy was also, of course, influenced by the month of pregnancy in which

the woman sought prenatal care. It will be called to mind that one-fifth of the white and two-fifths of the Negro women who received prenatal care from physicians or clinics made their first visit in the third trimester of pregnancy.

Care at Delivery.

Place of delivery.—About three-fifths of the white women and six-sevenths of the Negro women were delivered at home. For women who lived in the country this often meant that the attendant worked under the most primitive conditions. About two-fifths of the white and one-seventh of the Negro women were delivered in the hospital. For a small proportion of both white (2 percent) and Negro women (4 percent) the hospital care was of an emergency nature. It is important, however, that emergency cases comprised only 6 percent of all hospital deliveries among the white as compared with 24 percent among the Negro women.

Attendant at delivery.—Most of the white women were delivered by physicians, whereas about half of the Negro women were delivered by midwives. A very small proportion of the women of each race (0.6 percent) had no attendant at delivery.

Almost all the midwives in these counties are Negro women; none of them have had any institutional training. The State Department of Health, through the public-health nurses and health officers, attempts supervision as far as equipment goes and in matters such as the instillation of silver nitrate in the eyes of newborn infants and the prompt reporting of births. In another county of the State, not included in this survey, the midwives have received intensive instruction, with excellent results, from a trained nurse-midwife who is now doing similar but less intensive work throughout the State.

The percentage of deliveries with no attendant, although low, is higher than in Baltimore City, where, in the 3-year period 1936–38, only 2 unattended births took place.

Type of delivery.—Delivery was spontaneous for 92 percent of the white women and 97 of the Negro women. The larger percentage of spontaneous deliveries in the Negro group is related to the greater number of midwife cases. Physicians used operative means in delivering 8.6 percent of the white women whom they attended and 6.5 percent of the Negro women. This difference is too small to be considered significant. Women who attend clinics and who have planned delivery by midwives are referred to hospitals or to private physicians if it is thought that the delivery may not be entirely normal. The physicians, therefore, deliver a selected group, particularly in the case of Negro women.

Cesarean section was the operation used for delivery of 25 of the 78 white women and 7 of the 14 Negro women for whom delivery was operative. In the Johns Hopkins Hospital, which receives a large proportion of cases presenting abnormal conditions, 17.5 percent of the operations are sections. This study appears to show a relatively high incidence of Cesarean section among white women, but this may be largely because of the fact that most of the women who received hospital care at delivery were women in serious need of special attention.

Conclusions.

While it is recognized that this survey is deficient in many respects, the chief aim has been descriptive and the general character of the observations with regard to existing conditions seems to be reasonably correct. There are undoubtedly great shortcomings in the care received by rural women, particularly Negro women, in childbearing. These shortcomings are associated with lack of facilities, difficulty in making proper use of the facilities that are available, and the failure of some physicians to give the sort of care recognized as desirable and really essential. The importance of adequate obstetric care for all women must be brought home to general practitioners and emphasis placed on the minimum satisfactory standards for prenatal, delivery, and postnatal care.

The public needs to learn through precept and example what is comprised in good maternity care. This care should be made available to women who cannot provide it for themselves. As adequate obstetric care becomes more general, morbidity and mortality rates for mothers and newborn infants should be lowered.

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Some Social Considerations in the Provision of Maternity Care at Public Expense

By Beatrice Hall

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The improvement that is taking place today in maternal and child health may be regarded as a culmination of a fundamental concern on the part of citizens, which has actively expressed itself for many years in a variety of programs supported through public and private funds. It may also be regarded as one manifestation of increased awareness on the part of people generally of the influence of social and economic conditions upon the health of mothers and children and the development of greater skill in cooperative effort, making possible a fuller utilization of all community resources in meeting the total problems of individuals.

Early studies made by the Children's Bureau showed the close relationship existing between the health of children and the earnings of the fathers, the manner in which the infants were fed, sanitary conditions, the presence of the mother in the home, and the health of the mother before and after the baby's birth. It follows that the primary medical and social needs of mothers and children can be met only through cooperative work with families on the part of physicians, nurses, nutritionists, health educators and social workers, of health and welfare agencies in both public and private fields, and of professional organizations and citizens' groups.

In the maternal and child-health programs being administered by the United States Children's Bureau under the Social Security Act, the Federal Government, the States and local communities, the medical, dental, and nursing professions, professional and civic organizations, public and private health and welfare agencies are cooperating in a comprehensive partnership. Cooperative planning on a national level is facilitated by national organizations such as the American Committee on Maternal Welfare, the Maternal and Child-Health Section of the American Public Health Association, and the National Maternal and Child Health Council, a private organization which serves as a clearing house and advisory center for 60 diversified national organizations interested in health problems of mothers and children. In the administration of public medical services cooperative relationships have been developed between departments of health and welfare on State and local levels and other agencies in order to meet patients' needs most effectively.[1]

In a study of maternity care provided through the New York State relief program in 1935 and 1936, the Children's Bureau, in cooperation with the New York State Departments of Social Welfare and Health, reviewed the care given in six counties of that State in order to obtain information regarding the extent and cost of the care.[2] The field work, which was concentrated in the local areas, was done by four medical social workers from the Children's Bureau. In the course of the study recognized gaps in community services and problems arising out of the administration of medical care were brought to the attention of the field workers by local relief and health administrators. Case records also brought to light some problems of general significance in the provision and administration of maternity care concerned particularly with the procedures for authorizing care, the determination of eligibility, relation of medical and social factors,

[1] Cooperation in the Administration of Tax-Supported Medical Care. Committee on Medical Care, American Public Welfare Association, August 1940. See p. 23 for description of a cooperative program for maternity care in Cattaraugus County, N. Y.

[2] Maternity Care at Public Expense in Six Counties in New York State. Children's Bureau Publication, No. 267. Washington, 1941.

and provision for special needs related to illness. Conferences with local relief and health officials, physicians, nurses, and others also revealed significant problems in relation to the needs and practices of "medically needy" families—those able to maintain themselves but unable to pay for necessary medical care.

The New York State plan, under which maternity care was provided at public expense, and which had been in operation since 1931, was worked out jointly by the Temporary Emergency Relief Administration and the State Department of Health, with the aid of special advisory committees from the State medical, dental, and nursing organizations. The Manual of Medical Care, issued by the TERA, which contained the rules and regulations governing medical care provided in the home to recipients of home relief, included a statement of minimum standards for maternity service which emphasized prenatal care.[3] The plan was conceived and administered as a method of supplementing existing resources; it was described by the State relief administration as intended "to augment and render more adequate facilities already existing in the community," such as hospitals, clinics, and nursing services. Under the plan State funds could be used only to assist local welfare departments to pay for care in the home; local communities continued to bear the full cost of hospitalization. While medical care was restricted to persons who were recipients of home relief or who upon investigation by the welfare officer were found to be eligible for home relief, this regulation was interpreted in most welfare districts to include the group unable to pay for medical care, although able to provide themselves with the bare essentials of living. In the counties visited community resources and health programs differed considerably and illustrated various types of services developed with the help of State funds to supplement local programs. One of these counties included a city of more than 100,000 population in the midst of a rural area; no other cities of as much as 50,000 population were included in the study.

The methods by which maternity care is authorized are of the greatest importance to women needing care, to physicians, to agencies making payment, and to the taxpayers who eventually meet the costs. In the rural areas included in this study, authorizations for home and hospital care were issued by local (town) welfare officers, who worked under the general supervision of the county commissioners. These local welfare officers usually had no medical knowledge and no formal training in social work and sometimes had only a limited general education. The information which they considered necessary in making decisions to grant care was influenced by this lack of knowledge and training. In many instances it was limited to items of family income and current expenditures and did not include explanation of the medical situation, the health needs of the family or other social factors which should be considered in relation to the financial data. Although such information was frequently available to welfare officers through local public-health nurses, it was not consistently utilized as a basis for joint planning in behalf of patients.

Despite the fact that hospital costs were borne entirely by the local unit, no instance was noted of refusal by a welfare official to authorize hospitalization for a maternity patient for whom a physician had recommended hospital care. Some counties had a very high proportion of home deliveries, and unquestionably a much larger proportion of patients would have benefited by hospital care if greater consideration had been given to factors of crowding and lack of proper facilities in the home, distance from the local physician, and so forth, in making choice of home or hospital care. It is significant that in the area where decision as to home or hospital care was based on the medical and social needs of the individual patient 43 percent of the women deliv-

[3] The rules and regulations in the manual provided for a high quality of service and recommended that local commissioners of public welfare maintain lists of physicians and other licensed professional attendants who had agreed in writing to comply with them. It was further suggested that when a patient requested the services of a physician not already on an approved list the written authorization to the physician be accompanied by a copy of the rules and regulations and a statement that acceptance of the authorization implied compliance with these rules in giving professional care. In none of the communities studied, however, was there an adequate system of professional review of physicians' records to see that these provisions were being carried out.

ered were hospitalized, whereas in another county which hospitalized only patients for whom the physician recommended hospital care because of complications, 30 percent were hospitalized.

Some welfare officers, however, were not convinced of the advantages of prenatal care and did not encourage applications from women early in pregnancy. There was evidence that this attitude on the part of some welfare officers tended to discourage clients from making early application for prenatal care and that the effectiveness of efforts of public-health nurses to get women under care early in pregnancy was limited in some instances by the efforts of the welfare officers to curtail relief expenditures.

Extension of clinic facilities for prenatal care would have made it possible for women to secure care during this period without the delay incident to determination of eligibility. The prenatal clinic also affords an opportunity for study of the medical and social needs of individuals and the formulation of recommendations helpful to the welfare officer in authorizing care at confinement. In sparsely settled areas, however, clinic facilities cannot always be readily available to all women in need of care, and provision should be made to facilitate authorization for prenatal care by private physicians.

Since the medical need as well as the social situation of patients should be considered in granting authorization for care, procedures of authorization for maternal care should be in the hands of individuals who have an understanding and appreciation of the principles of good maternity care. Ideally, final decision can best be made by a well-qualified physician on the staff of the agency authorizing care, who has been given responsibility for reviewing the report by the physician attending the patient and the recommendation of the social worker who is familiar with the social situation.

It is recognized that great difficulties are involved in introducing such procedures in local administrative units that are not large enough to permit effective and economical administration of medical-care programs under the direction of a physician. A practical temporary solution may be to devise means of giving local health and welfare workers increased understanding of the basic principles involved in the provision of medical care at public expense and of the social and psychological factors related to health that require consideration in the determination of eligibility. This may be brought about through specialized consultation services from the State staff and through advisory services of district and local health officers and physicians. Since this study was completed, the New York State Department of Social Welfare (to which the functions and powers of the Temporary Emergency Relief Administration were transferred on July 1, 1937) has added medical social workers to its staff and some local offices have made similar appointments. Provision has also been made in some counties for the county medical director or medical consultant to perform the same functions for town welfare departments as for the county department upon the request of the town and upon its agreement to conform to the policies and procedures of the county plan.

Physicians who are giving freely of their skill and time in the treatment of patients on relief rolls have a right to expect the relief administration to provide for the special needs of their patients which are related to the medical problem. A physician treating maternity patients should receive cooperation from the relief organization in early referral of cases; assistance in follow-up unless that responsibility is assumed by another organization; provision for enabling patients to receive a liberal diet in all instances, with special needs met upon the physician's recommendation; help in planning confinement care with the assistance of a nurse if the delivery is to be in the home; housekeeping service and essential household equipment when necessary; and planning for the care of other children in the home during the mother's confinement and convalescence. Anxiety and apprehension on the part of the patient often limit the effectiveness of medical care; it is the responsibility of the social worker and the public-health nurse to aid the physician in dealing with these factors.

In rural areas, where relief offices are staffed by incompletely trained social workers with heavy case loads, meeting these special needs

is a difficult problem. The difficulty is greatly lessened, however, if there is a qualified public-health nurse who serves the area and with whom the relief worker may cooperate. The relief worker cannot provide intelligently for the patient's needs unless she has an understanding of her condition in terms of disability and work capacity, activity limitation, prescribed treatment, and prognosis. She needs to know whether the pregnant woman is able to do all her own housework, whether she needs special food, and whether the physician has made any special recommendations. The public-health nurse can be of great assistance to the relief worker in these circumstances, and the social worker and the nurse can work out a division of responsibility for various phases of treatment of individual patients. Conferences from time to time with a medical-social worker are helpful to local workers in developing policies for cooperative effort and in treatment of individual cases, since the medical social worker is especially equipped to advise on social problems connected with health and medical care.

In some of the areas included in the New York State study the medical needs of clients were effectively explained to relief workers by the county nurses. In one such county, where there was close cooperation between the public-health nurse and the relief-work supervisor, no emergency authorizations for delivery care were noted. In one small city the welfare commissioner and the medical-social worker at the local hospital worked closely together, and in another city the director of the home-relief bureau and the superintendent of the city hospital supplemented each other's efforts intelligently and efficiently. In these areas records gave evidence of a recognition of the interrelationship of medical and social factors; the effectiveness of medical treatment was enhanced by the consideration given by relief workers to the special needs of individuals.

These are a few of the ways in which local relief and health administrators are working together in the provision of maternity care at public expense. General provision of public medical care, including maternity care, is at the present time in many States a responsibility of welfare rather than health departments. Twenty-five State health departments, however, are providing, in a few areas, medical or hospital care for maternity patients or sick children under plans approved by the Children's Bureau. The Committee on Medical Care of the American Public Welfare Association has expressed its belief that the immediate and important problem is not *who* should administer tax-supported medical care but how it should be administered.[4] The statement of the committee stresses the fact that the scope and amount of care should be sufficient to include all necessary preventive and curative service required by persons unable to procure it for themselves and that the service should be provided under conditions which will encourage its full use. It is further stated that the medical and social needs of the individual patient should be related and that an effective program for persons on relief should be closely integrated with a general assistance program providing food, shelter, and clothing. Other recommended principles of administration include coordination and integration of services through cooperative relationships eventually leading to centralized responsibility for the administration of preventive and curative services, the adoption of minimum qualifications for practitioners and minimum standards for agencies based on the advice of professional groups and the maintenance of these standards by means of professional supervision.

In planning extension of facilities for maternal care, it is of particular importance to devise procedures for the authorization of care which will make such facilities available to all women unable to obtain care through their own resources. In other words, the determination of eligibility should not be conducted in such a way that the "medically needy" woman will defer making an application for prenatal care in the hope that her financial situation will improve sufficiently to enable her to pay for care. In the statement referred to previously, it is recognized that the determination of med-

[4] Organization and Administration of Tax-Supported Medical Care; a tentative statement of essentials and principles. Committee on Medical Care of American Public Welfare Association. December 1939.

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ical need should be a medical responsibility and should precede the determination of financial eligibility and that procedures for determining eligibility should not delay necessary treatment.[5] Furthermore, women who apply for maternity care present varying medical and social needs. Consideration of the individual's need is a fundamental concept in the practice of medicine and of social work, and an important consideration in an adequate maternity-care program. The results of medical treatment are influenced profoundly by the availability of resources to meet these special needs and by the skill with which the services of varied organizations are employed in behalf of the individual. The effectiveness with which the medical and social needs of individual women are met and the extent to which care is available to all women unable to meet their own needs is the real test of any community program for maternity care.

Consideration of an individual problem encountered in the provision of care may reveal gaps in community resources, limitation of programs through inflexible and restrictive policies, or failure to correlate essential services in meeting a total situation. Such problems constitute focal points for concerted action by the community.

[5] Authorization of care at public expense, as it relates to hospital care, is discussed in detail in a statement entitled "Hospital Care for the Needy," prepared by a joint committee of the American Public Welfare Association and the American Hospital Association and available through the office of either association.

Nutrition Defense Committees

By Helen S. Mitchell, Ph. D.

Principal Nutritionist in the Office of Defense Health and Welfare Services, Washington, D. C.

Any attempt to reach the 130 million people in the United States with an action program to meet their needs in terms of food must be made by people who understand the varying local problems and resources of different parts of the country. Some State nutrition committees were already in existence when the national nutrition program was conceived as a defense activity, and these were used as a nucleus for Nation-wide cooperation with Federal authorities in translating nutrition information into action. The National Nutrition Conference for Defense, which was held in May 1941 at the call of Federal Security Administrator Paul V. McNutt and of the National Nutrition Advisory Committee, stimulated existing State and local groups to increased activity and inspired other States to set up similar organizations. By July every State, as well as the District of Columbia, Hawaii, and Puerto Rico, had its own nutrition committee with broad representation from public and private agencies. Today several States have set up their programs on a county basis. The unit of organization in the local level is, of course, the neighborhood or community.

Functions of a Nutrition Committee.

Leadership in developing a nutrition program best suited to the needs and conditions of a particular area rests with its nutrition committee, but in general their activities follow similar patterns. Before a committee can begin to develop a program, it must, of course, survey nutrition activities of existing agencies and ascertain to what extent these are meeting the needs of its people—geographically, economically, and socially.

In the light of the knowledge thus obtained and of whatever other information is available, including pertinent studies, each committee has then tried to analyze the nutritional situation in its State to determine the most urgent needs—those requiring immediate attention—and to decide by what means they can best be met.

Membership of the Committees.

Not all nutrition committees follow the same pattern in their organization, but most of them include representatives of State agencies in the fields of agriculture, home economics, health, welfare, and education. In addition, many State

nutrition committees include representatives of the Farm Security Administration, the National Youth Administration, the Surplus Marketing Administration, and the Work Projects Administration. Other Federal agencies, such as the Children's Bureau, the Extension Division of the Department of Agriculture, the Office of Education, the Social Security Board, and the Public Health Service are represented indirectly through the State agencies that are carrying on programs under Federal grants-in-aid. Private groups from which membership may also be drawn are State medical, dental, nursing, dietetics, and home-economics associations, private health and welfare agencies, schools, colleges, labor auxiliaries and racial group associations and other lay organizations. The American Red Cross, a quasi-government agency, is frequently represented.

In short, every agency that carries on nutrition activities in the area and is willing to cooperate in the National and State nutrition program, is a potential member of the State or local committee.

Interrelationships.

Relation of National office to State nutrition committees.—In the National Office of the Director of Defense Health and Welfare Services, M. L. Wilson is the assistant director in charge of nutrition. About once a month a news letter goes out from this office to all State nutrition committee members. Thus State workers are acquainted with developments in the national program and in other States. Frequently these news letters contain discussion of subjects requested by State committees or suggestions regarding organization or specific activities. They also contain notices of available materials, such as folders, pamphlets, exhibits, and nutrition scrap books. Whenever possible, the Nutrition Division is glad to respond to requests for speakers at regional or State nutrition conferences.

Relation of State committees to county and local nutrition committees.—County and local nutrition committees have been organized in many States with the encouragement of State committees. Through these, especially when set up in cooperation with local defense councils, the citizen can readily find a means of joining an action group to promote better nutrition in his own community through a variety of projects. These vary widely—preparing news releases for the local press and radio; promoting discussion and study groups; setting up exhibits and distributing posters; assisting in the school-lunch program; and working with food purveyors and distributors to educate the public.

Another important avenue through which the local committee brings nutrition information to members of the community is the local library. The American Library Association has recently published a nutrition bibliography in *Booklist*, which goes to 7,500 member libraries. Public demand for up-to-date and authoritative information on nutrition will encourage libraries to order these materials.

Relation of nutrition committees to State and local defense councils.—The work of the nutrition committees obviously ties in closely with that of State and local defense councils under the Office of Civilian Defense. To fit in with their plans to have an information center in each locality where the willing volunteer may learn the requirements of various projects, a Manual on Nutrition in Defense is being prepared in Washington.

Activities Reported by Nutrition Committees.

Many committees are already reporting good results from several types of activities.

Refresher courses were held during the summer in 18 State colleges and universities. These were attended primarily by home-economics teachers, home-economics-trained home makers, home demonstration agents, Farm Security Administration workers, and social workers from departments of public welfare.

State-wide conferences or nutrition institutes lasting 1 to 3 days or longer have been found successful in several States as a means of orienting a community or group in the aims of the national nutrition program. In some States these conferences have been called by the Governor. One State held a nutrition institute attended by 102 Negro preachers who, according to reports, are spreading the message of better nutrition most effectively in their parishes. In Ohio the committee organized five regional institutes during the spring as a result of which a State-wide refresher course was given in con-

nection with a nutrition conference. The California committee has sponsored a 2-week defense nutrition institute. The third annual nutrition institute in New York State was held at Cornell University in July.

Adult classes in nutrition have been organized in a few places and are received with enthusiasm. In Virginia 200 white women and 84 Negro women completed such a course, and more courses are being planned. Mattress centers of the Work Projects Administration, where people are using surplus cotton for making mattresses, are also being used as teaching centers for giving information on nutrition to workers.

Speakers' bureaus, set up in some localities, assist clubs and other organizations to include nutrition in their programs.

Community gardens and community canning projects.—Of the many community gardens established this summer those especially successful were in Negro communities where they had never had gardens before. Many of the gardens were on school grounds, and the canning was done at community canning centers.

School-lunch programs are being planned on an extended and improved basis in most States, thanks to help from Surplus Marketing and Work Projects Administration. In many communities where they were needed acutely they have proved an excellent starting point for a community nutrition program.

A Look Ahead.

All this is only a beginning. Much of the work of the committees so far has been of an experimental nature, a trying out of various methods and activities. As they find the avenues of approach that appeal most to their people and meet most effectively conditions in their own States, results should be increasingly helpful. These results should show first in improved food choices, such as an increasing demand for "enriched" or whole-wheat products, and in more effective use of surplus commodities and more widespread home growing of vegetables. Ultimately the value of the nutrition program should prove itself in terms of health and well-being, improved physical and mental stamina for millions of people who, whether they know it or not, have lacked the health and vigor that comes from an abundant and well-chosen diet.

Civil Defense Measures for the Protection of Children, Dr. Martha M. Eliot's report of observations in Great Britain, February 1941 as a member of the Civil Defense Mission to Great Britain, has now been released for publication. A limited number of copies of the report in mimeographed form are available from the Children's Bureau for the immediate use of local administrative authorities.

• CHILD WELFARE •
• SOCIAL SERVICES •
• CHILD GUIDANCE •

Interpreting Child-Welfare Services in Rural Areas [1]

By Ruth M. Werner

Children's Worker, Walworth County, Wis.

At a club meeting in a rural county the child-welfare program was being discussed. Child-welfare services had been in operation in the county for more than 2 years, and the governing board of the county had reached the point of considering whether the program should be made a permanent one, supported by county funds. One woman said:

> You need expect no support from me in keeping that child-welfare worker. She hasn't done a thing to get that Sue out of this town. There Sue sits with her two children. No one knows who the father of either one is, and I hear there'll be another soon; at least I wouldn't be surprised. Everyone knows Sam's been living up there and supporting her all winter, and you can't tell me they're married, either.

But another woman protested:

> Well, that may all be but if there's anything I can do to help you can count on me. If Miss Frank hadn't done one other thing, what she did for Janet Schmidt and her little 2-year-old child would convince me that she is someone worth having around. You know the Schmidts were living near us when Ted came home drunk and beat that baby until he was black and blue all over, even his ears. Miss Frank came out to see what was wrong, and it didn't take her long to see that Janet and the baby were taken care of, and Ted, too.

The importance of first-hand knowledge of case-work services in influencing individuals is shown by this bit of discussion. No less important than case-work service is the interpretation of the program to the community in the light of case-work principles.

The problem of interpretation in a rural county is different from that in an urban setting where social agencies and publicity channels are well-established. Into a rural county comes one worker whose responsibility it is to develop a program of child-welfare services in such a way that the people of the county will find this service essential and therefore decide to make it permanent.

Although each county, like each individual case, presents a different set of factors and no two can be handled exactly alike, there are a few general principles that can be applied in work with counties.

To begin with, need for the services must be felt by some group, perhaps the juvenile court, perhaps the county parent-teacher association or federation of women's clubs, perhaps the men's service organizations. This consciousness need not be general throughout the county, but it is the responsibility of the State worker to see, before a local worker is assigned to a county, that there is some group to which she may look for understanding and help in relating the program to the larger community.

The worker must obtain some information about the county as the basis for diagnosing the needs and making plans. How do the residents think of the county? What national and religious groups are to be found? What is the economic situation? What are the sources of tax funds? What government units are there?

[1] Paper given at joint session of the Child Welfare League of America and the Social Work Publicity Council at the National Conference of Social Work, Atlantic City, N. J., June 3, 1941.

Some of this information comes from collateral sources and some from people within the county. The worker in turn discusses her services in general terms and gives examples, always following leads which the community offers as she would follow leads in a case-work situation. Just as every worker must make clear to people in need of help how her services are related to their needs, a rural worker must present to the county the services offered by the whole child-welfare program. Here the ability of the worker to understand and to accept the local situation, to like the people and be liked by them, is important.

The worker realizes that services related to problems which the county recognizes, and for which help is asked, have most meaning to the county. As the relationship between the worker and community grows stronger, there will be a broadening of the base of understanding and a growing acceptance of the wider range of services which the worker can offer. The readiness to recognize need for services varies from individual to individual and from group to group. It depends on the nature of the problems presented, on whether help is desired, on the extent to which the worker is accepted, and on the degree to which the services are understood. When groups within the county are convinced that the services are essential, they in turn act as interpreters, and general understanding and acceptance gradually become sufficient so that the services are organized as a permanent county function. In this connection, some remarks of Dr. Krueger's seem applicable. He states:

> Educating a community calls for skillful approaches and it will be accompanied often enough by heart-breaking failures to get local residents to overcome their own warped attitudes toward problem families and persons. We venture the suggestion, however, that communities can learn to deal with their problems and that when they succeed, we shall have a powerful aid in creating a preventive program.[3]

This would entail a shift from the case-work processes. When a person gains complete understanding of his problem, he should have a better integrated personality with less need for social service. But only a beginning has been made in the establishment of a permanent program in a community when the community as a whole has recognized its problems, understood the need for social services in dealing with them, and accepted responsibility for organizing such services.

In the county which I shall use as an illustration, there was a group which was conscious of the need for child-welfare services—the county parent-teacher association. The State representative of the Children's Division had been working with this group for 2 years. Although not county-wide in scope, the group had called a county-wide meeting which resulted in requests to the State office for the service. The worker went to the county in response to these requests. The executive committee of the county parent-teacher association formed the nucleus of an advisory committee. Other members were the juvenile-court judge, the county superintendent of schools, and the director of the public-assistance agency. They felt from the beginning an interest in the program; it was theirs.

From the State worker and her records, the worker learned some facts about the county. More were learned in day-to-day contacts with members of the advisory group. The county is entirely rural and has a population of less than 10,000. It has poor soil, and the people must struggle for a living; but the public-assistance load has never been high, and the county has remained free of debt. This has been accomplished partly by the conservative policy of the governing body of the county which preferred to refuse FERA funds rather than to accept outside supervision. Only a year before the worker came in, the county rejected an offer from the State Board of Health to subsidize a public-health nurse to the extent of $2,000 if the county would appropriate $500. A strong conservative group in the northern part of the county supported these policies.

In the southern part of the county, the struggle between fundamentalists and modernists has caused rifts in churches and communities. Religious friction has affected the

[3] Krueger, E. T. Community Planning for Preventive Services. *Bulletin of Child Welfare League of America*, January 1940, p. 3.

lives of young people by limiting the recreational program of the schools. As a result, the young people flocked to taverns and public dance halls in connection with the taverns.

There was a county federation of women's clubs in addition to the parent-teacher association, but neither one extended into the northern section of the county.

The county had experienced almost no professional service in the field of social work. The public-assistance agencies had limited their services to meeting financial needs with Federal aid.

As the worker began to function in this setting, it was necessary for her first to explain to the advisory committee and to key people in each community what services she could render. The committee met monthly, and in addition to a report on the worker's activities, discussed some phase of a program of child-welfare services: Foster homes, adoption, or work with unmarried parents and the child born out of wedlock. A foster-home study was presented to the group to show what the worker looks for in a foster home. The State consultant on adoptions discussed her field of interest with the group. The worker called on the ministers, physicians, and school principals throughout the county explaining her work. And at this stage committee members arranged for the worker to meet with groups in various communities. This interpretation served to give a basis for understanding to many people before they had contact with the program through cases.

About a year after the worker had come into the county, she visited a family in which the parents were separated and the mother was experiencing difficulty in maintaining a home for her 11-year-old daughter. At one time the mother had gone to work and placed Mary with her grandmother. Mary had not liked this and, when a return to this plan was suggested, Mary said to her mother, "Let's talk to Miss Frank first. I heard her talk at school, and she cares about what happens to children." So, in at least one instance, someone in the audience was able to relate the services as outlined to her particular problem!

At this early stage, as always, service rendered in individual situations was the most effective means of interpretation. In accepting cases referred to her by other agencies, and in reporting on them, the worker had an opportunity to explain how she could be of service and to stimulate thinking in relation to a recognized problem.

Three months after the worker arrived, a case of serious neglect and abuse came to the attention of the juvenile court when the father of four children was jailed. The mother had deserted. The judge of the juvenile court had been in office only a few months. He was open-minded but wondered if there was any need for child-welfare services in this small and rural county. The judge told the worker that perhaps she could be of some help, but that he thought he already knew what he would do with these children; he would send them to the Catholic institutions maintained by the diocese. The worker agreed that this might be a good plan but suggested that perhaps a study made in the community would be helpful to the Catholic agency. It was found that the boy, 12 years of age, had been with his grandmother a great deal. He was the child most upset by the whole situation. A study of the grandmother's home showed that she was willing and able to care for this child. For the other three children the Catholic agency did seem the best solution, for this agency had a flexible program offering both institutional and foster-home care, whereas the child-welfare service was so new in the county that a foster-home program had not been started. The worker got in touch with the Catholic agency. The fact that the worker was able to relate her services in an acceptable fashion to a problem confronting the judge marked the turning point in his attitude; he became a staunch advocate of the program and considered it a service he could not get along without.

In a rural area, far more than in an urban one, the citizenry generally are aware of families receiving service. If results in one case prove to be to the interest of the community, support for the program is forthcoming; but if it is believed that the measures taken were not drastic enough, criticism is sure to follow. This fact emphasizes the need for a general understand-

ing that the service is a helping one, not a punishing one. Such an understanding also enables people to accept service without feeling stigmatized. A continuing educational program, then, is needed in addition to case-work services; this program should be designed to meet varied levels of understanding.

Here again the advisory committee members were helpful. They received monthly reports on the number and kinds of requests for service, the cases closed, and the services that had been rendered. They did some reading suggested by the worker. Some of the members attended State conferences and regional meetings of the Child Welfare League of America. The committee members were growing in understanding and ability to answer inquiries regarding the program, to straighten out misconceptions. They were better able to bring to the worker an understanding of community attitudes.

While the committee was developing to the point where it could take an active role in the educational program, the worker was becoming a part of the county so that her fellow citizens began to say, "Miss Frank belongs to us." She attended church services in the various communities, church suppers, school programs, the educational workshop, basketball games, and public card parties. She learned to know people on a friendly plane. They accepted her as really one of them because she shared their experiences. As they learned to know her informally, they also got some inkling of the nature of the service which she represented, for the worker represented the service in everything that she did and said.

With the preliminary work completed, the time came to solidify the program in the community with greater public understanding. The worker followed the leads that were offered. The county governing body was the key group, since it had the power to decide whether the service should continue. It received a report from the committee and from the worker. The worker's report was mimeographed on colored paper, and placed special emphasis on what the services save in dollars and cents, hard though that may be to estimate. But how much did the members to the governing body really know and understand of what was being done?

"Why not send them a questionnaire and find out?" the judge suggested when this was discussed in committee 6 months after the program started. He agreed to help work out the questionnaire.

Has the child-welfare worker done any work in your town or village which in your opinion was necessary?

Do you believe such work saved your town present or future expense?

Did such work help the children involved?

Would it have been done without the services of the worker?

Are the people in your town aware of the services which the worker will give if requested?

Do you know of anyone needing her services now?

So ran the questions. Surprisingly, 17 of the 21 of the questionnaires were returned, and the replies were favorable to the child-welfare work. One suggested that a list of services would be helpful. This was the next lead. A mimeographed folder which would fit in a business-size envelope was made on colored paper with illustrations. It gave the aim of the program and listed family situations and children's problems [3] with which the worker might be able to help. Five hundred of these folders were sent to physicians, attorneys, ministers, and were distributed at meetings at which the worker talked and at county fair exhibits.

Exhibits at county fairs provided another opportunity to bring information to the citizens of the county. One year a bad home situation was contrasted with a foster home in doll-house fashion. Another year, a toy Ferris wheel was used. Each section illustrated an influence which children need: a good home environment, the school, the church, wholesome recreation, community protection. These served as attention-getting devices and gave the worker opportunity to discuss the program with individuals who might otherwise have had no contact with it. Maps and charts were used in presenting facts.

Free outdoor motion pictures attract large crowds in rural sections during the summer months, and the advisory committee was able to arrange with the local sponsors to show slides calling attention to the child-welfare services.

[3] Child Welfare in a Wisconsin County. *The Child*, vol. 3, No. 12 (June 1939), p. 269.

A sketch of a donkey kicking up his heels carried the caption. "Don't kick about your troubles. See your children's worker." A little boy on a stepladder called attention to the scope of the service with the statement, "Climbing up!! One hundred forty-eight children from 50 different families in this county helped by the children's worker during May alone." Five such slides were rotated in four communities in the county throughout the summer months. One parent, after seeing these slides, for the first time realized that the worker with whom he had had casual contact was particularly interested in helping with children's problems, and he came in to ask help with a nervous, high-strung youngster who was reacting unfavorably to the financial pressure and uncertainty in the family situation.

The weekly newspaper printed special articles and reprinted the reports to the county board. A person visited in a section of the county where the worker had done little, immediately identified "the children's worker about whose work I've been reading."

In the various ways mentioned efforts were made to spread information and understanding of the service, but it was recognized that participation in the program is important. A member of the committee and the worker prepared a panel discussion to meet this need. It was in the form of a conversation to be read by the worker and two members of the group with whom the program was being discussed. This was a start. Then packets of material were distributed by the committee to ministers and local discussion groups. These packets included general information on child welfare, the Children's Bureau pamphlet [4] entitled "Community Social Services for Children," information regarding the State program, the folder describing the services offered locally, and information on how the program was set up and its scope. The individuals and groups to whom these packets were given were asked to present to their groups discussions based on this material. It was thought that the persons who studied the material would gain a better understanding of the program, and that having the discussion led by a member of the group would result in more participation.

The educational program now plays a supporting role to services rendered to families and individuals and after 2½ years the citizens of this county are aware of the value of child-welfare services to their county and are interested in having the service continued. It was in response to this feeling on the part of the citizenry that the governing body of the county took favorable action.

This county has its own problems and characteristics. The techniques used in interpreting child-welfare services here may not be applicable elsewhere, but the underlying philosophy on which the techniques are superimposed would seem to have general application. It is important that the county, or at least some group in it, should recognize the need for help with child-welfare problems. Then the worker must come to understand and know the community. Services must be interpreted in relation to needs which the county recognizes. An educational program must accompany case work and give support to it, but case work itself is the most effective means of education. As the people of the county recognize that the service is meeting their needs they will assume responsibility for making it permanent in the county.

[4] U. S. Children's Bureau, Folder 7 (revised). Washington, 1939.

BOOK NOTES

Plays for young people

Plays—The Drama Magazine for Young People is a new periodical published by Plays, Inc., Boston, Mass. The first number is dated September 1941 (Boston, 1941, 96 pp.). This issue contains 16 plays and radio scripts designed for performance by pupils in grade schools with the purpose of instilling in them an appreciation of democratic traditions. It is announced that the magazine will be published monthly from September through June at a price of 30 cents a copy, or $3 a year.

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How To Teach Children Music, by Ethelyn Lenore Stinson. Harper & Bros., 1941. 140 pp. $1.50.

This book relates the experience of the author in planning and adapting a course in the study of music appreciation for the exceptional children in the Woods Schools at Langhorne, Pa. The course of study, methods of teaching, and approach to the problem, which succeeded in helping each of these children to find beauty and inspiration in music, should be of value to teachers of normal children who can learn more quickly than the children at Langhorne but who may be untalented or without interest in music.

By the use of large instrument charts and pictures of instruments and artists the children were given an opportunity to use and develop their visual memory. By the requirement that each child do a certain amount of handwork, the use of the kinesthetic sense was encouraged. Phonograph records and radio programs stimulated the auditory images of the children.

Texts and reference books, with an explanation for the use of each, are listed by the author. Changes are suggested in the usual procedure of teaching music appreciation in order to make it easier for the children.

Physical Education for Small Elementary Schools, by Harold K. Jack. A. S. Barnes & Co., 1941. 184 pp. $1.60.

The author, supervisor of health and physical education of the Minnesota State Department of Education, presents a detailed program for teaching physical education to children in small and rural elementary schools. Games, stunts, and drills for use in all eight grades are suggested. The book contains chapters on the techniques of teaching physical education and the objectives of elementary-school physical education.

Play for Convalescent Children in Hospitals and at Home, by Anne Marie Smith. A. S. Barnes & Co., New York, 1941. 133 pp. $1.60.

That a directed play program can be a constructive experience for children during the several phases of hospitalization is the theme of this book. Play is discussed as part of an integrated hospital program contributing to an understanding of the child, to development of his mental and social potentialities and his education, and as one of the several forms of therapy available in the well-equipped medical unit.

A play program as described here is more than the provision of play equipment to keep the child occupied and quiet. Its soundness and value are based on an understanding of the psychology and needs of children individually and as members of a social unit and on professional development of such a program by personnel educationally and personally suited for the responsibility.

The emphasis of the author is on the well-rounded hospital program to meet total needs of the whole child rather than "play" itself. Illness is recognized as imposing physical restrictions on the child as well as affecting his temperament and personality. Although the interplay of physician, nurse, social worker and play-program personnel is both mentioned and implied, the interaction and interrelation of their respective services in relation to particular situations could be further developed with value.

As Miss Smith points out in the foreword, "Although this book deals with the child in the hospital situation, the activities, the principles, the values of play and of group methods are applicable to children anywhere." The book should be of considerable assistance to individuals participating in a play program since it treats organization and administration of such a service, techniques of play leadership, and content of program. Included are suggestions for literature, games, and activities which require and which do not require material equipment.

The discussion is based on observations of a 6-year experience at the Children's Memorial Hospital, Chicago, where an experimental development was the cooperative venture of the Sociology Department of Northwestern University, the School of Pediatric Nursing of the Children's Memorial Hospital, and staff members of that 250-bed hospital. Introductory and advanced courses were developed for student and staff nurses and additional sessions prepared for other hospital personnel. It would appear that from this theory and practice the nurses increased their understanding of children and their ability to work with them for effective nursing care. R. T.

• CHILD LABOR •
• YOUTH EMPLOYMENT •
• VOCATIONAL OPPORTUNITIES •

The Census Counts the Child Workers of the Country

By Beatrice McConnell

Director, Industrial Division, U. S. Children's Bureau

In 1790, within a year after the election of its first President, the new Republic of the United States of America began the series of Nation-wide counts that at 10-year intervals ever since have given a picture of this country and its people. That first census, covering population only and taken for the purpose of determining the representation of the individual States in the lower House of Congress, was the beginning of periodic and increasingly comprehensive inquiries that have been of incalculable value in determining the extent and trend of the social changes occurring during a century and a half of our national life.

The growing complexity of our national problems may be indicated to some degree by a comparison of the 4-million population of 1790 with the 132 million of 1940; of the 6 or 7 simple queries of that first census with the hundreds of questions now included in census schedules dealing with population, agriculture, and manufactures.

The facts which these censuses reveal serve to illumine many social problems—problems as varied as the individuals that make up the people of this country. One of the most vital measurements for which people look to these figures is that of the employment of children and youth. It was not until 1870 that the special problems of child labor were recognized as of sufficient importance to demand the attention of the national census, although occupational data for all persons 15 years of age and over had been obtained in the censuses of 1850 and 1860. With the year 1870 information about employment of children 10 to 15 years of age inclusive was obtained, and this practice was followed until 1940, when the information obtained on employment of children was limited to those 14 years of age and over.

Tabulation of the complete census findings requires a period of many months, and in order to furnish as soon as possible a general picture of the more important facts gathered, preliminary estimates based on a 5-percent cross section of the population enumerated in each of the 154,000 census-enumeration districts have been compiled. These figures are, of course, subject to correction when the final statistics become available.

According to these preliminary estimates there were in round numbers 4,800,000 boys and girls 14 and 15 years of age in the United States in March 1940 (4 percent more than in 1930), and 4,900,000 boys and girls of 16 and 17 years (5 percent more than in 1930). These numbers include all children of these ages, regardless of whether they were in the labor market, in school, or otherwise occupied. As the amount and kind of employment of young persons is to a large extent dependent upon work opportunities, the type of locality in which these children live is significant. The number of boys and girls 14 to 17 years of age, inclusive, living in rural nonfarm areas was markedly greater in 1940 than in 1930—an increase of 15 percent—and the number living in urban areas also increased, though to a less degree. In rural

TABLE 1.—*Population 14 to 17 years of age, inclusive, in urban, rural nonfarm, and rural farm areas, United States, 1930 and 1940*

Area and population group	14 to 17 years inclusive			14 and 15 years			16 and 17 years		
	1930	1940 [1]	Percent change	1930	1940 [1]	Percent change	1930	1940 [1]	Percent change
United States, total	9,341,221	9,749,150	+4.4	4,678,084	4,843,381	+3.5	4,663,137	4,905,769	+5.2
Urban	4,704,237	4,995,454	+6.2	2,330,954	2,457,440	+5.4	2,373,283	2,538,014	+6.9
Rural farm	2,902,991	2,762,140	−4.9	1,470,981	1,385,382	−5.8	1,432,010	1,376,758	−3.9
Rural nonfarm	1,733,993	1,991,556	+14.8	876,149	1,000,559	+14.2	857,844	990,997	+15.5

[1] Preliminary figures, estimated on the basis of a 5-percent sample tabulation of the 1940 census returns.

Source: 1930—Fifteenth Census of the United States: 1930, Population, vol. III, pt. 1, p. 17. 1940—Unpublished data from U. S. Bureau of the Census.

farm areas, on the other hand, there was a decrease of 5 percent between 1930 and 1940 in the number of children of these ages (table 1).

Although because of differences in definition the 1940 census figures for employment were not collected on the same basis as those for 1930, the number of young persons recorded as "in the labor force" in 1940 may be compared roughly to the number recorded as gainful workers in 1930. The "labor force" in 1940 was defined on the basis of employment status during the week of March 24–30. It comprised, first, persons actually having jobs in private employment or nonemergency Government employment; second, those at work on Government emergency projects; and third, those out of work but actively seeking employment during the week when the census enumeration was taken, including a considerable number of new workers who had never held a job. The 1930 data on gainful workers comprised all persons usually following a gainful occupation, regardless of their employment status at the date of the census (April 1, 1930). It is probable that considerable numbers in certain groups—for instance, seasonal workers neither working nor seeking work at the time of the census—were included among gainful workers in 1930 but, in general, were not included in the 1940 labor force. On the other hand, the 1940 census includes in the labor force persons seeking work without previous work experience—that is, new workers—few of whom were included in the 1930 group of gainful workers.

Child labor in the decade 1930–40 was influenced by many factors having a tendency to reduce the numbers of children employed. These factors included a decline in employment opportunities for all workers and also advance in legislative child-labor standards, both State and Federal. It is not surprising to find, therefore, that the number of working children 14 to 17 years of age, inclusive, and particularly those 14 and 15 years of age, decreased considerably during this period, despite the slight increase in the total population of this age group previously noted. Nevertheless, the census figures show that in 1940 more than a quarter of a million children 14 and 15 years of age, and more than a million boys and girls of 16 and 17 years were in the labor force of the country. The number of 14- and 15-year-old children reported as in the labor force in 1940 was 41 percent smaller than the number of children of the same ages reported as gainfully employed in 1930, and the corresponding difference for the 16- and 17-year-old group was 29 percent (table 2).

About two-thirds (890,976) of the boys and girls 14 to 17 years of age inclusive in the 1940 labor force were reported as actually employed, including 213,104 children of 14 or 15 years and 677,872 of 16 or 17 years. These figures represent, in general, boys and girls employed during the week March 24–30 on private jobs or Government work of nonemergency character.[1]

[1] Although there is reason to believe that the 16- and 17-year-old group includes a few thousand young persons who were on National Youth Administration student-work projects or in Civilian Conservation Corps camps and who should, therefore, have been reported as emergency workers rather than as employed, this error was probably too small to distort seriously the total figures on employment.

TABLE 2.—*Number of children 14 to 17 years of age, inclusive, in labor force in 1940, compared with number of gainful workers of same ages in 1930, by sex, United States*

Sex of children	14 to 17 years inclusive			14 and 15 years			16 and 17 years		
	1930	1940 [1]	Percent change	1930	1940 [1]	Percent change	1930	1940 [1]	Percent change
Total	1,910,631	1,302,652	−31.8	431,790	255,336	−40.9	1,478,841	1,047,316	−29.2
Male	1,262,976	924,052	−26.8	298,482	198,941	−33.3	964,494	725,111	−24.8
Female	647,655	378,600	−41.5	133,308	56,395	−57.7	514,347	322,205	−37.4

[1] Preliminary figures, estimated on the basis of a 5-percent sample tabulation of the 1940 census returns.

Source: 1930—Fifteenth Census of the United States: 1930, Population, vol. V, p. 345. 1940—Unpublished data from U. S. Bureau of the Census.

They do not give a complete picture of the extent of employment of boys and girls under 18 years of age, as they do not include working children under 14. The 1930 census recorded a total of 235,328 workers 10 to 13 years of age inclusive—205,563 in agricultural work and 29,765 in nonagricultural work. This figure for 1930 was generally considered to be an understatement, because of the very large number of young children known to be employed in certain occupations, particularly in industrialized agriculture, street trades, and industrial home work. How many were employed in 1940 cannot be definitely stated, but there can be no doubt that employment of children of these ages still continues.

In both years the fact that the census was taken in early spring inevitably resulted in omitting from the count many children of the ages covered employed in agriculture. Although some commercial crops are under cultivation as early as April 1, the vast majority of the children who engage in industrialized agriculture are not employed at that date and would not have been counted in the labor force as they would not have been regarded in the last week of March as "seeking work." [2]

[2] A farmer who usually operated a farm was recorded as employed even though because of bad weather conditions, or other reasons, he did not actually work on the farm during the given week; but his children, to be recorded as at work, must actually have worked during the week on tasks contributing to the income of the farm (other than home housework, occasional work, or incidental chores). It is, therefore, probable that some children may have been counted in 1930 as having the "usual occupation" of farm work, whereas in 1940 children in the same status would not have happened to work during the given week and would not be counted as in the labor force, for they would not have been thought of as "seeking work."

No figures showing the industries in which children were employed in 1940 are as yet available. However, the relative numbers of young workers resident in urban, rural nonfarm, and rural farm areas furnish some indication of the distribution of children employed on nonemergency work as between agricultural and nonagricultural employments. Sixty-eight percent of the employed children of 14 or 15 years reported by the census lived in rural farm areas and only 19 percent, in urban communities. Among the 16- and 17-year-old workers, the concentration in farm areas was somewhat less, but farm residents nevertheless made up 49 percent of the group, compared with 35 percent who were urban residents and 16 percent who lived in rural nonfarm areas.

A reduction in employment of children, particularly those under 16, such as is indicated by the 1940 census figures, is to be regarded as a social gain, as it means a lengthening of the period open to the coming generation for schooling and for physical and mental development. But labor statistics are seldom static. Already greatly expanded production, under the defense program, is directly affecting the employment of young persons. There has been a sharp increase in employment of boys and girls 16 and 17 years of age, and, along with this, there is evidence that a rise is also occurring in the employment of children under 16. Any upswing in general employment tends to be accompanied by an increase in child labor; in addition, the present emergency is inevitably causing pressure on child-labor standards. It is vitally important that such pressure should not be permitted to fall upon the children of

the Nation who, more than ever before in our history, need all possible opportunities for training to fit them for the heavy responsibilities awaiting them in the future.

International Labor Conference

New York, October 27, 1941

The International Labor Conference which will open in New York on October 27 is the first since the Conference held in Geneva, Switzerland, in June 1939. The Conference scheduled for 1940 was postponed because of the outbreak of war in Europe.

The agenda includes a report by the International Labor Office on collaboration of organizations of public authorities, workers, and employers. The report of the Acting Director, Edward J. Phelan, will present a broad survey of the main economic and social trends for the past 2 years and will outline the future policy of the International Labor Organization, which at present has headquarters in Montreal.

The Washington Office of the International Labor Organization has issued a release stating that representatives of governments, workers, and employers of various nations throughout the world will attend the New York Conference. All general sessions of the Conference will be open to the public.

The first International Labor Conference, October–November 1919 was held in Washington, D. C., and a technical conference on the textile industry was held by the International Labor Organization in Washington in 1937. Two special regional conferences, one in Santiago, Chile, in 1936, and the second at Habana, Cuba, in November–December in 1939, have been held in the Western Hemisphere. Except for the 1919 Conference, however, all general conferences of the International Labor Organization have been held at its former headquarters in Geneva.

Maternal and Child-Health Examinations

Examinations for positions as specialist in maternal and child health with the Children's Bureau ($3,200 to $5,600 a year) have been announced by the United States Civil Service Commission. Options are offered in pediatrics, obstetrics, or orthopedics. Vacancies in State agencies cooperating with the Children's Bureau may be filled from these examinations at the request of the States. Application forms can be obtained from the Civil Service Commission in Washington, from the United States Civil Service district offices, or from first- or second-class post offices; applications must be on file not later than November 15, 1941.

CONFERENCE CALENDAR

1941

Oct. 9–11 American Academy of Pediatrics. Annual meeting, Boston, Mass. Secretary: Dr. Clifford G. Grulee, 636 Church Street, Evanston, Ill.

Oct. 20–26 Better Parenthood Week. Material and information from Better Parenthood Week Committee, c/o *Parents' Magazine*, 52 Vanderbilt Avenue, New York.

Oct. 27–Nov. — International Labor Conference, New York.

Nov. 2–8 Children's Book Week. Twenty-third annual observance. Book Week Headquarters: 62 W. 45th Street, New York.

Nov. 9–15 American Education Week. Information and Material from National Education Association, 1201 Sixteenth Street NW., Washington.

Nov. 11–14 Southern Medical Association, St. Louis, Mo.

Nov. 12–14 Eighth National Conference on Labor Legislation, Washington. Called by the Secretary of Labor.

Nov. 14–15 Child Study Association of America. Two-day institute on Family Morale in a World at War, New York. Permanent headquarters: 221 West Fifty-seventh Street, New York.

Dec. 4–6 National Society for Prevention of Blindness. Annual meeting, New York. Permanent headquarters: 1790 Broadway, New York.

1942

April 6–10 Second American Congress on Obstetrics and Gynecology, St. Louis Mo. General Chairman: Fred L. Adair, American Committee on Maternal Welfare, Chicago, Ill.

May 2–9 Eighth Pan American Child Congress, Washington, D. C. (Postponed from March.)

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